

CALIFORNIA AGING AND DISABILITY RESOURCE CENTER INITIATIVE

- 1. Executive Summary** The California Department of Aging (CDA) is seeking an Aging and Disability Resource Center grant in the amount of \$800,000 to be used over a three-year grant period to develop the “California Aging and Disability Resource Center Initiative.” The goal of this initiative is to develop effective Resource Centers, highly visible in the community, that provide the public with easily accessible, understandable information, counseling and/or assistance, and program linkage to the full range of aging and long term support options; benefits counseling; LTC planning; and health promotion that will enhance individual choice, support informed decision-making; and foster public understanding and use of home and community-based supports.

This Initiative involves a “One Stop” approach to the services provided at the Resource Centers, simplifying not only the number of places, but the eligibility and assessment processes, consumers must go through to obtain assistance. Without question, a successful California program will require a partnership across agencies and programs at the state and local level. CDA is submitting this grant with Area 1 Agency on Aging, applying on behalf of Del Norte County and San Diego County Aging and Independence Services. These agencies will establish a Resource Center in their county in collaboration with a number of committed partners. Key activities will include: (1) analyzing how current programs and processes can be simplified and consumer information and access to aging and long term support options improved; (2) conducting Resource Center public awareness activities to make these Centers highly visible; (3) targeting outreach to underserved or hard-to-reach groups through community partnerships and use of local mobile Info Vans, particularly in rural areas; (4) identifying potential modifications to the Network of Care website to enhance this tool’s usefulness; (5) identifying and partnering with particular physicians and their staff who will champion the cause of building bridges between the health and social service networks, since physicians are often key advisors to families in long term care decision-making and have little time to directly be establishing these linkages for patients.

2. Problem Statement As California's population grows, it is also growing older and more diverse. In 1998, the state had approximately 32.7 million residents, representing 12% of the entire United States population. Californians age 65 or over are projected to reach 4.5 million by 2010, far exceeding the projected national growth rate. California's population age 85 and over is our fastest growing age group and will grow 200% in the next 40 years. It is also the age group most likely to need long term care assistance.

More than 40% of the state's baby boomers are African American, Latino or Asian and one-third were born outside this country. By 2040, the majority of California's older adults will be from groups now considered to be ethnic minorities. Several of these groups have lower life expectancies than their white, non-Latino counterparts due to language, economic, and health access barriers encountered over their lifetime.

Many urban and suburban retirees have been and continue to be enticed to move to more rural areas of the state by the beauty, slower pace, and lower housing costs in those areas. But these rural areas are especially unprepared to support a growing aging population, since their limited aging and health resources are already stretched thin accommodating a geographically dispersed population.

According to the 1990 census, 20.7% of California's total population (4.6 million) has a disability, including difficulty in self-care activities. Approximately 1.5% (507,000) of the population is estimated to have a developmental disability (DD). Using national statistics, an estimated 21% (6.8 million) of the state's population has either anxiety or mood related disorders. California is also home to more individuals with AIDS than the national average. While the total number of AIDS cases continues to decline, persons with AIDS are living longer and at some point will need substantial long term supports.

When Californians need long term care supports, they are most likely to receive that help from those who are close to them: family, other loved ones, and their local community. Some individuals

purchase in-home assistance privately. Many older adults move to assisted living facilities, which far outnumber nursing facilities in California. The In-Home Supportive Services Program (IHSS), adult day health care, and the Medi-Cal (California's Medicaid program) home and community-based (HCB) waiver programs also support Medi-Cal beneficiaries in the community.

CA Aging and LTC Service Delivery Given California's population and geographic size, most state programs are administered primarily through contracts with local counties or with other local agencies. Medi-Cal is administered by the CA Department of Health Services (DHS) and operated at the local level by county social service departments, which also administer the In-Home Supportive Service (IHSS) Program. DHS also administers the Preventive Health Care for the Aging (PHCA), a partnership of local and state public health agencies. PHCA increases access to prevention services for older adults; provides health education; and promotes collaboration among local health providers and organizations serving older adults. Both Del Norte (DN) and San Diego (SD) counties, sub-grantees in this proposal, participate in this program.

Through an interagency agreement with DHS, the Department of Mental Health (DMH) administers the Mental Health Waiver through county mental health agencies. DMH also oversees the network of 11 Caregiver Resource Centers serving family caregivers of individuals with adult-onset brain disorders. The Department of Developmental Services (DDS) provides Medi-Cal and non-Medical services to persons with developmental disabilities through a network of regional centers.

The California Department of Aging (CDA) is the State Unit on Aging administering Older Americans Act and Older Californians Act services through 33 Area Agencies on Aging (AAAs). Only a third of the state's AAAs are under the auspices of county government, although this is the case in most large urban areas of the state. CDA also administers the Multipurpose Senior Services Program, the Medi-Cal HCB waiver through 35 local contractors. CDA certifies adult day health care centers for Medi-Cal participation and also operates a toll-free consumer phone line throughout the state that automatically routes callers to the AAA in their calling area.

The Department of Rehabilitation (DoR) administers federal Rehabilitation Act funds. Two DoR programs of particular relevance in this proposal are the Independent Living Centers (ILCs) and the CA Assistive Technology System (CATS). California's ILCs provide information and referral (I&R), independent living skills training, housing assistance, and personal assistance. CATS advocacy and grassroots projects seek to make assistive technology available to persons with disabilities through information and referral services. Both programs will be valuable assets for the Aging and Disability Resource Centers (hereafter simply referred to as the Resource Centers).

County Grant Partners CDA is applying for this grant with two sub-grantees: Area 1 Agency on Aging (A1AA), applying for Del Norte County, (DN) and San Diego (SD) County Aging and Independence Services (AIS).

University Research Partners In 1999, the University of Southern California School of Gerontology and the University of California at Los Angeles (UCLA) Multi-campus Program in Geriatric Medicine formed a collaborative Center for Long Term Care Integration (LTCI) to provide technical assistance to the CA DHS and local entities pursuing LTCI, described in "State LTC Initiatives" below. AIS has worked with the Center for LTCI on additional specific SD data analyses and on other LTCI design and implementation issues. SD has also contracted with Mark Meiners, Ph.D., University of Maryland Center on Aging Center on Aging, who is the Project Director for the Robert Wood Johnson funded Medicare-Medicaid Integration grant program, for specific consultation services.

Medi-Cal Eligibility and Level of Care Determinations In California, financial eligibility or Medi-Cal is determined by county social services departments. For most HCB waiver programs, the local contractors perform the level of care (LOC) assessment. The exceptions are the In-Home Medical Care Waiver, the Nursing Facility (NF) A/B Waiver and the NF Subacute Waiver. These three waivers are directly operated by DHS Medi-Cal In-Home Operations who directly perform those LOC assessments. Medi-Cal In-Home Operations will provide training on these waivers to the sub-grantees to promote coordination between waiver unit staff and the Resource Centers in identifying and assessing potential

waiver clients. Nursing facilities complete the client Pre Admission Screening Review and also submit Medi-Cal Treatment Authorization Reviews documenting medical necessity.

Barriers in Accessing Services The various federal and state programs providing income, health and social supports to older adults and persons with disabilities—all with their own eligibility (income and disability level) and program benefits, create what is frequently described as a “patchwork” or “maze” of uncoordinated services.

While acute and chronic health conditions frequently translate into the need for LTC supports, there is very little coordination between health and social service providers. Frequently, the need for LTC is precipitated by an acute health episode. An emergency room visit or hospitalization and potentially a short term post-acute nursing home stay may be warranted. But fiscal pressures force hospital or nursing homes to discharge quickly. Little time provided to help residents and their families organize the timing and needed supportive services to transition home. Physicians, who families tend to rely on in making these decisions, usually know very little about HCB services and how to help patients access them. These descriptions of our health and LTC realities at the national level also reflect the reality in California.

So persons eligible for public programs may go without services and those able to pay privately may receive more costly services than necessary or turn to private referral agencies taking “placement fees,” which are not likely to direct clients toward HCS options. Those neither wealthy enough to pay out-of-pocket or poor enough to qualify for public programs are left with very few options.

These inherent structural problems make it difficult for consumers, health and social service providers and family caregivers to arrange efficient, appropriate and desirable assistance. As a result, institutional LTC often becomes the default outcome, which is neither desired or responsive to consumer preferences, nor is it necessarily the most cost effective option.

California may be “service rich” compared to many other states. But each of these programs functions independently with no overarching coordination mechanism. While many programs are tied to Medi-Cal financial eligibility, they have different disability criteria, assessment tools, and are administered by different agencies.

The fiscal and organizational structures of the current health and long term support programs, coupled with a fundamental Medicaid institutional bias result in services that are neither responsive nor sensitive to the needs and preferences of many consumers who desire to receive care in the home and community and make their own decisions about daily activities, work, health care, etc. The “system” is still based on the acute, episodic medical model even though long-term disabilities are more prevalent and often need non-medical support services.

The loss of a single component of an individual’s support system – such as housing, transportation or a caregiver – can result in institutionalization, even though the consumer’s functional status or health may not have changed. And once institutionalized, it is extraordinarily difficult to transition back to the community – especially if family supports are not readily available .

This single grant cannot solve all the structural and programmatic LTC re-design issues. However, in the context of federal, state and local Olmstead efforts and the New Freedom Initiative investments, this grant can make it easier for CA consumers and their families to find understandable information on their long term support options; get assistance in making informed choices; and become eligible and access services in a straightforward and timely manner.

This California proposal builds on programs, tools and relationships already in place to address the global challenges discussed above and the unique characteristics of these two counties. Equally important, California’s local resource centers will be based on a consumer-directed model that recognizes and emphasizes the consumer’s desire for individual choice, direct involvement in making healthcare related decisions and the preference to receive care in the home or community rather than in an institution.

Regional Overview-Del Norte DN is in the far northwestern corner of the state, eight hours from the urban areas of San Francisco or Portland, OR. This is a 1,000 square mile rural wilderness with only one interstate highway that is closed repeatedly during the winter. Access to health care is often limited for both public and private-pay residents due to distance and limited

providers. Isolation, coupled with the limited economic opportunities, makes it challenging to develop and deliver supportive services to aging and disabled county residents.

DN has a total population of 23,810, approximately 16% are age 60+. Among this age group, 90% are Caucasian, 4% Native American, 3% Hispanic, 1% Asian and .02% African-American. Approximately, 20% are classified at “greatest economic need,” at or below 125% of poverty level. An estimated 5,600 DN residents over age 5 have a disability. This rate increases significantly with age--11.4% of those ages 5-20, 26.5% of those ages 21-64 and 44.6% of those ages 65 and over reporting some disability. Older adults and persons with disabilities are usually on fixed incomes and frequently hit hard by rising medical, energy, and fuel costs. Over 20% of the total population has income below the poverty level.

Given the significant state urban issues and the population size needed for pilot programs, small rural counties are often left out of grants and cross-disability LTC collaborations, though their needs are equally pressing. However, DN’s small population is an asset in this project. DN has one hospital and one nursing home. Doctors do know about the HCB services and make referrals. Though geographically spread out, “everybody tends to know everybody,” which makes developing better coordinating of those few resources available a simpler task.

Regional Overview-San Diego SD County is a mixture of urban and rural communities, from coastal beachfront to mountains and desert, spanning 4,300 square miles. The fourth largest U.S. county and California’s second most populous, SD is roughly the size of Connecticut. Yet much of SD is also rural. Agriculture is an important sector of the county’s economy.

SD is home to 2.9 million residents, with growth projected to reach four million by 2020. The county is already ethnically diverse, and will become increasingly so. SD’s population is 60% White, 24% Hispanic, 9% Asian, 6% Black, and 1% Native American. Nearly 19% of the county’s population are immigrants and speak 68 different languages. The county has 18 Native American Tribal reservations, more than any other single county in the country. Between 1995 and 2020, SD’s Hispanic population will more than double. Hispanics will then comprise one-third of the total population.

The gateway to aging and disability services in SD is the already existing Call Center, which operates two toll-free phone lines providing access inside and outside the county. Calls go through a Centralized Screening to determine eligibility for an appropriate referral to the broad array of services managed by AIS. This Call Center has merged I&R, care management, and program intake (eligibility, assessment, and enrollment), and elder and dependent adult abuse reporting functions to streamline the process for consumers and assure linkage to appropriate programs.

State LTC Initiatives Assuring public access to accurate, understandable, comprehensive information on long term supports to make informed LTC choices has been a growing concern in CA. Many counties are developing consolidated, shared web-based databases to reduce duplicative database maintenance activities and assure that all consumers will get the same I&R based on the needs presented. Several CA state initiatives and bridge-building efforts have created new tools and partnerships that will be strategic assets in building successful CA Resource Centers:

- Web-based tools:

Network of Care (NoC) Website (www.networkofcare.org)— Developed with a state seed grant, 14 counties have now “bought” customized county-versions of the NoC. (only the Resource Finder database is county-specific so all other components can be used throughout the state.)¹ A statewide Mental Health Network of Care has also been developed. The website incorporates:

- o A resource finder to locate services, facilities, and assistive devices;
- o Consumer-entered health information that can be shared with providers and family members, personalized notes, links, and a personal “Hot List”;

¹ There is often concern that older adults, persons with disabilities, and low-income individuals lack access to Internet resources. CA is careful to make information available in various formats. However, Internet use has grown rapidly here and is the place many now turn first for information. SD gets an average 10,000 hits a month on its NoC website. Analysis of Californian’s using Benefits CheckUp indicates the following user characteristics: 52% are at or below 200% of poverty; 43% disabled; 58% age 65+; 63 % were seeking info for themselves or a spouse. A June 2000 Harris Poll found that adults with disabilities, on average, spent twice as much time online; were much more likely to report that the Internet improves their quality of life; and report that it helps them feel connected to the world and reach out to others with disabilities. This is a valuable consumer resource CA must continue to refine.

- o Consumer-focused information on health conditions, risk-factors, treatments, and health promotion;
- o Web site builder function to assist community-based organizations in developing their own web site.
- o Caregiver support (message board, chat, articles);
- o Links to local, state and national legislative bills, updates, and programmatic/ financial eligibility determination for public programs.

Benefits CheckUp website helps consumers and agency staff identify public benefits an individuals may qualify for and directs the user on how to apply for that specific program. Both of these web-based programs can be used at the Resource Centers in matching consumers with needed information and identifying a broad range of benefits for which they may be eligible.

- **Collaborative Efforts between Aging and Disability Interests**—Over the past several years, the CA Association of Area Agencies on Aging (C4A) and the CA Foundation for Independent Living Centers (CFILC) have been increasingly working together in their advocacy and educational efforts. The joint annual conference held by these organizations continues to grow in attendance and enthusiasm. The CDA and DoR developed a Memorandum of Understanding in 2002 visibly reflecting the growing collaboration between the two state departments on these issues.
- **Long Term Care Integration (LTCI)**—Since 1995, efforts have been underway to develop Medi-Cal waiver pilot programs, similar to those in Wisconsin, Texas and Arizona, that integrate the full range of health and LTC supportive services for aged, blind and disabled beneficiaries through a capitated payment system at the county level. Under this model, fiscal and programmatic incentives would be aligned so that the money does “follows the person.” DHS has provided provide planning and implementation grants to support these efforts. San Diego has been actively involved in this effort.

Conceptually, CA is moving from a “single point of entry” to a “no wrong doors” approach for initial consumer contact which can then be seamlessly routed to a centralized Resource Center model.

CA's goal in this proposal is to develop effective Resource Centers, highly visible in the community, that provide the public with easily accessible, understandable information, counseling and/or assistance, and program linkage on the full range of aging and long term support options; available benefits; future LTC planning; and health promotion that will enhance individual choice, support informed decision-making and minimize confusion for all consumers, providers and caregivers.

- 3. Target Population** California's proposal includes all target populations identified in the federal grant solicitation. The DN Resource Center will serve adults age 60 and over, individuals of all ages with physical disabilities and family caregivers. These individuals are already beginning to come to the county's Family One Stop, but the Center is not currently adequately prepared to respond to these aging and disability information and assistance requests. So expanding the existing DN Family One Stop to serve these additional groups is a natural program evolution.

The SD Resource Center will target all county residents, serving older adults and individuals of all ages with physical, mental health, developmental, and traumatic brain injury-related disabilities as well as caregivers and potential caregivers of all individuals in these groups. This will permit SD to address one of its key implementation steps in achieving LTCI—refining a coordinated system for I&R, assistance, assessment and care coordination that will serve the entire aged, blind and disabled population and their caregivers.

- 4. Proposed Intervention** While DN and SD may be polar opposites in terms of population density, resources and the multicultural spectrum, they will both create Centers that incorporate the grant goals by focusing in on improved links between health care and social support providers; more effectively using web resources; exploring effective outreach to underserved target group members; and identifying viable strategies for urban, suburban AND rural areas. Each county's proposed intervention reflects the geography, resources, existing organizational structures and relationships, and the most pressing needs in those areas.

- Developing coordinated I&R and outreach program to streamline access to aging and long term supports using a “One Stop” model. This program will be physically housed at the existing Del Norte InfoCenter in Crescent City.
- Co-housing key services at Resource Center. In 2003, ILC, HICAP (Health Insurance Counseling & Advocacy Program) and Healthy Families will begin regular office hours at the DN InfoCenter. (Medi-Cal financial eligibility and other income support services are already there.) Bringing these services into a “One Stop” Resource Center will improve both the individual’s, and family caregiver’s, ability to access information on and access to needed support options with less calls, trips, and frustrations.
- Taking the Resource Center on the Road. A1AA recently purchased a “mobile resource center” vehicle, in partnership with the DN Children & Families Commission. The vehicle is configured to support multiple agencies (i.e. ILC, Public Health, DN InfoCenter) during single or consecutive outreach trips. With grant funding, an outreach plan will be designed to bring Resource Center information and services to the target populations in the most remote County areas.
- Designing and maintaining information on Resource Center clients (adults 60+ and the disabled) to produce client-based information to produce unduplicated count data reports. The current database (IRis) tracks client intake, needs assessment, care plans/services, and service utilization. Building on existing resources, A1AA will design an unduplicated data collection system that could be used by other AAAs and other interested agencies. (Other funding has been set aside for these modifications and any others required by this grant.)
- Expanding DN InfoCenter Website to include resources for these target populations. Currently, the InfoCenter maintains a website with service information and links to community/senior calendars for all ages. Grant will permit site expansion to include information/activities relevant to persons with disabilities and caregivers. The regional service database will be expanded to include support services responsive to the needs of all the grant’s target sub-populations.

The DN project will also welcome families, caregivers, and professionals in the community who share a commitment and concern for individual choice and improved access to and range of long term support options. Individuals seeking employment will be linked to openings and added to the A1AA registry.

San Diego Over the past twenty years, SD has built an infrastructure that will support the development of a Resource Center and, as a next step, will use that Resource Center as a component in its LTCI program implementation. Activities will include:

- Evaluating the effectiveness of the current Call Center (with a Centralized Screening Process) and the NoC. Clients and staff will assess satisfaction; identify problem areas; make suggestions for improvements; enhance NoC as a communication tool and community resource instrument.
 - Analyze Call Center services, centralized screening process and NoC with focus groups, including Call Center staff, consumers, providers, and caregivers;
 - Define and make Call Center and NoC changes as identified in focus groups;
 - Examine interest in the NoC “My Medical Record” as consumer tool for health/ social services info voluntarily share on-line via pass code with family or providers;
 - Explore potential use of NoC web page builder function to encourage small local organizations to develop a simple web page linked to the NoC so the public can quickly view special services or program features (e.g., target population, special programs, languages spoken, etc.).
 - Identify and implement other needed tasks to transition the Call Center into a Resource Center; and
 - Identify how to systematically continue this process as part of AIS’ Continuous Quality Improvement (CQI) program.
- Conducting public education and training programs on long term support resources to increase use of Resource Center and NoC.
 - Secure human resources to organize and complete training programs;

- Hold periodic trainings at the Resource Center and naturally occurring community gathering places for seniors, caregivers and persons with disabilities (e.g., Senior Centers, libraries, pharmacies, hospitals, clinics, physician group offices, Regional Centers, health and social service providers' offices, etc);
- Examining key current consumer pathways to long term support information and decision making to improve collaboration between local physicians and health and social service agencies; analyze and address ethnic disparities and challenges in serving ethnic minorities and persons with disabilities already identified by the local public health community; identify and make recommendations re: possible solutions and effective/appropriate outreach methods and localities.
 - Identify professionals that consumers, and families rely on in LTC decision making for involvement in developing Resource Center interventions and outreach; and
 - Identify and work with selected physicians ready to champion this partnership approach.
- Taking the Call Center on the Road. The AIS Info Van will be used for outreach and public education targeting naturally occurring neighborhoods of diversity:
 - Use CA Health Interview Survey database to sort San Diego neighborhoods by age, disability, and ethnicity to target outreach;
 - Work with community partners serving minority and disability groups to identify individuals who are underserved or under-utilizing services;
 - Employ AIS Community Outreach & Education staff and grant funded staff/translators and bi-lingual health and human service professionals to provide targeted outreach, education and assistance to targeted ethnic minority groups;
 - Publicize and conduct "Benefit Analysis" clinics, using culturally appropriate outreach staff, to help individuals access needed services in targeted locations that will attract underserved/under-utilizing subpopulations.

- Creating Visibility for Resource Center:
 - Design and print Resource Center brochure and handouts for dissemination at community outreach events, local physician offices, community-based service organizations, and other appropriate localities identified during focus group testing;
 - Develop Resource Center press releases and print public service announcements for local newspapers and magazines, including those targeting caregivers, seniors, and persons with disabilities and/or minority groups; and
 - Create effective radio public service messages to reach identified target populations. These would be used on AIS's own weekly radio program and other modes of telecommunication identified in focus group testing.

AIS has a sophisticated management information system and has the capacity to modify or expand that system, if necessary, to collect information required for project evaluation purposes.

5. Involvement of Key Stakeholders Both DN and SD will develop an Advisory Committee. CDA will assure that the subgrantee's meet the provisions for consumer taskforce participation that apply to the overall Real Choice Systems Change Grants for Community Living in terms of the composition of their Advisory Committee; that consumers are supported in preparing for those meetings to assure their meaningful participation; and that assistive technology and alternative formats are available as needed.

Del Norte The A1AA has successfully convened and participated in numerous advocacy and program planning groups and is experienced in coordinating workgroups that successfully incorporate active consumer involvement. In developing an Advisory Committee, the DN project staff will recruit existing and new consumers, public and private partners, and appropriate new stakeholders in all stages of analysis, planning, implementation, monitoring and evaluation activities.

Key stakeholders will include: DN Senior Services Collaborative; Tri County Independent Living, Inc.; LTC Ombudsman; FIRST 5 -DN Children & Families Commission; DN County Dept. of Health & Social Services; DN County Mental Health; Redwood Coast Regional Center; DN Association of

Developmental Services; DN Senior Center; Veteran's Services; A1AA direct programs including: HICAP (our state health information counseling program), Senior Information & Assistance, Caregiver Registry, Volunteer Center of the Redwoods and Retired & Senior Volunteer Program; Community Health Alliance of Humboldt-DN, Inc; DN Healthcare District; A1AA Advisory Council; and the Older Adult Mental Health Advisory Committee.

San Diego AIS has a long history of involving broad consumer, provider, and other stakeholder input in its various efforts. In developing an Advisory Committee for this grant, consumers, family caregivers and representatives from the following groups will be included:

Long Term Care Integration Project stakeholders (450 health and social service providers and consumers/caregivers); Area Board XIII for Persons with Developmental Disabilities; AIS Advisory Council; Healthcare Association of SD and Imperial Counties; Network of Care Advisory Council; In-Home Supportive Services Public Authority; County Medical Society; SD Association of Non-Profits; and CA Long Term Care Integration Center.

6. Performance Goals and Indicators The following Performance Standards will be used to monitor success in achieving core goals articulated in the grant solicitation:

Visibility

1. Centers use creative means for building community awareness, outreach, and targeting potential users, going beyond just brochures and posters in senior centers and libraries.
2. Physicians and other professionals refer their patients and clients to Resource Centers.

Trust

1. Center locations are in non-stigmatizing public places frequented by all kinds of people.
2. Community input is incorporated into the Centers' plan for outreach, locations, access sites, services, performance standards, and quality indicators.

Accessibility

1. Information and assistance is accessed by private pay as well as Medi-Cal beneficiaries.

2. Multiple avenues of access are offered that reflect current lifestyles and younger target populations (i.e. on-line, commuter-targeted, everyday-life centered).
3. Currently underserved populations are specifically targeted for outreach and education.
4. All materials are available in alternative formats and languages spoken by 10% or more of the target population.

Responsiveness

1. Center staff ensure that clients are referred for needed medical care as well as social supports.
2. Staff *only* perform activities for clients that they cannot perform for themselves (for empowerment, legal and practical reasons).
3. Workers are knowledgeable about all long term support service options (home- based, residential, health care, institutional, etc.) as well as financing options including LTC insurance, managed care plans, disease management programs, preventive services, and lifestyle change programs.
4. People admitted to nursing homes are contacted regarding their future choices.

Efficiency/Effectiveness

1. Need for clients to travel is minimized.
2. Community partners who can support/help underwrite center's continuation are included.
3. New information systems and websites are complementary to existing ones or incorporate them, rather than creating the need for more separate data input, both within the local area and across agencies and across the state.
4. Information systems are set up to identify service gaps, underserved areas, etc.
5. People in nursing homes are assessed for potential to transition to more independent living environments.
6. Private pay consumers have access information on cost effective strategies for securing the full range of supportive services, accessing preventive services, lifestyle changes, etc.
7. Outreach to at-risk, non-publicly-funded consumers is coordinated with healthcare providers.

8. Plans of care include preventive and rehabilitative medical care, as well as supportive services.
9. Informal supports are enhanced and maintained.
10. Self care is enhanced and maintained or increased.

7. Evaluation The evaluation of the two counties' Resource Centers will focus on collecting information that will assist them to improve their operations over time. This information will also help CDA and AoA determine the overall effectiveness of the Resource Center concept. These evaluations will be formative and process oriented. The Center for LTCI and University of Maryland will provide technical assistance in program evaluation. In addition, San Diego's NoC will also be evaluated in the context of the Resource Center and SD's more long range LTCI goals. Separate funding is being sought for the in-depth NoC evaluation.

Formative evaluation that feeds information back into the program design process:

1. To what extent were identified activities in the work plan (a) completed and (b) timely?
 - If delayed or not completed, why? What barriers were encountered? How were these overcome? What was the ultimate result?
 - What were positive lessons learned that can inform future programs?
 - What unplanned activities were carried out and why? What were the results?
2. Consumer and provider feedback.
 - Focus groups and strategic surveys.
3. Compare and contrast the experience of these two very different counties, and also of various subgroups and targeted underserved areas and populations.

Potential indicators of impact to be further developed and refined by the Advisory Councils:

- Decrease in number of times the same information is collected by different providers and agencies.
- Decrease in the number of calls/trips/home visits required to establish eligibility, determine care needs, develop care plan, and begin receiving services.

- Formal enrollment coordination between the Centers' LoC assessment and financial eligibility staff.
- Substantial increase in the general public's awareness of the Centers and how to access it.
- Increase in the number of inquiries over current I & A, looking at specific subpopulations and consumer characteristics.
- Change in source of referrals to I & A/Resource Centers: Physician, NoC, hospital, SNF, paramedics, senior center, phone book, radio, etc.
- Mobile vans – targeting to underserved areas, number of visitors, number of referrals made, effectiveness in providing the full range of ADRC services, rate of increase in use.
- Targeted/underserved populations – numbers served, rate of increase in numbers served, staff with appropriate language and cultural skills.
- Satisfaction among different user groups: (a) caregivers, (b) private-pay, (c) young disabled, (d) information only vs. more intensive users, (e) nursing home residents, (f) foreign language speakers and cultural minorities, (g) rural residents, (h) elders, (i) general public, (j) providers, (k) other underserved groups, etc.
- Satisfaction with sub-programs: (a) benefits counseling, (b) mobile vans, (c) website/NoC.
- Consumer knowledge about service options and how to access them.
- Increase in numbers of functional screens over time, particularly among targeted underserved groups.
- Providers' knowledge and utilization of the service to enhance services to their clients.
- Service gaps identified and action plans developed by the county.
- Cost-effectiveness of providing I & A to private-pay consumers.
- Utilization of HCBS and residential care increase at a higher rate and use of nursing homes continues to plateau or decreases.

- Public seeking Medi-Cal eligibility for nursing facility placement are aware of alternative HCB support options.
- The values and performance standards listed in the previous section will be further defined with the input of the advisory group and operationalized for more precise measurement.

8. Dissemination Project status reports will be given to the CA CHHS Agency LTC Council and the Olmstead Advisory Group at their quarterly meetings throughout the grant period. Grantees will make presentations on activities, tools being developed, and coordination challenges and accomplishments at scheduled state conferences of the CA Welfare Directors Association; the Allied Conference sponsored by the C4A and the CFILC; state caregiver conferences; and other appropriate meetings. These presentations will keep other local organizations informed and promote additional project partners. Other local initiatives developing resource centers will also be encouraged to participate in these sessions to facilitate resource sharing and minimize the need to reinvent the wheel throughout the state.

Sub-grantees will provide regular updates to local stakeholders through Advisory Committee meetings, media releases and other appropriate county forums. Information will also be available on the counties' websites. Project evaluators will be encouraged to submit their findings to publications that address federal, state and local governing topics and/or aging and disabilities issues.

9. Project Management

State Level CDA Chief Deputy Director, *Lora Connolly*, will be the lead state grant manager. The Chief Deputy Director reports directly to the CDA Director and is the primary CDA representative on the CHHS LTC Council Executive Subcommittee. She will meet via teleconference with the DN and SD sub grantees monthly to review work plan accomplishments, timelines, implementation issues, and identify state-level involvement needed. On a quarterly basis, crucial LTC Council departmental representatives will meet with the local grant partners to review progress-to-date, provide technical assistance and/or policy guidance as required.

Del Norte The Aging and Disability Resource Center project will be operated by A1AA. *Marianne Nix*, Project Director, will have the ultimate program responsibility for the project and will chair the Advisory Committee. *Susan Rossiter*, Project Manager, will be responsible for the day-to-day leadership and management, assure that Work Plan activities are completed; solicit broad and meaningful consumer, provider and other key stakeholder involvement in the planning, development and implementation processes; and will be the key Resource Center liaison with state, SD County, DN Dept. of Social Services and other partnering local agencies.

San Diego AIS will operate the county's Aging and Disability Resource Center Program. Project Director, *Pamela Smith*, will have ultimate responsibility for the project. She will serve as liaison with the Director of Health and Human Service Agency and the County Board of Supervisors and will chair of the Resource Center Advisory Group.

Project Manager, *Evalyn Greb*, will have the same project responsibilities as the DN Project Manager. She will also be the key Resource Center liaison with state, and DN County (AAA1) and County of San Diego agency staff, the Resource Center Advisory Board as well as consultants, partner organizations and other key stakeholders.

AIS Call Center Manager, *Rick Wanne*, will be responsible for direct oversight of Call Center activity; addressing relevant issues with the Resource Center and NoC database. AIS Outreach Staff Manager, *Joaquin Anguera*, will take lead responsibility for overseeing, scheduling, coordinating, and completing outreach & education activities.

Contractors:

Mark Meiners, Ph.D. (University of Maryland) and Kate Wilber, Ph.D (USC-UCLA Center for LTCI). will lead the evaluation team and perform the functions and activities outlined in the Evaluation Section.

Community Development Outreach Training Professionals will conduct periodic trainings on the NoC at the Resource Center and naturally occurring community gathering places for seniors, caregivers and persons with disabilities.

Special Populations Outreach Staff will assist AIS Community Outreach & Education staff in targeted outreach, education and assistance to various ethnic minority groups (e.g., Hispanic, Asian, Native American and Russian), and disability groups (mentally/physically/developmentally disabled) on long term support options, programs, services, eligibility, etc.

Translators/Interpreters (e.g., Spanish, Russian, Korean, Japanese, Chinese, Braille, Sign Language) will assist Special Populations Outreach staff in their outreach efforts.

10. Work Plan (see attachment for DN and SD Work Plans)

11. Organizational Capacity

State Level The CDA is the designated State Unit on Aging in California. It also administers the Medi-Cal HCB waiver for the elderly. State level interdepartmental collaboration on this grant will be achieved through the CA Health and Human Services (CHHS) Agency Long Term Care (LTC) Council, the Olmstead Advisory Group, and the Council's Executive Subcommittee. The LTC Council is chaired by the Secretary of the CHHS Agency and includes the directors of the Departments of Aging, Developmental Services, Consumer Affairs, Health Services, Housing and Community Development, Mental Health, Rehabilitation, Social Services, Transportation, Veterans Affairs, as well as the Director of the Office of Statewide Planning.

The LTC Council's goal is to improve interdepartmental coordination of LTC programs; improve quality of care; and expand home and community-based care options. The LTC Council is the lead state entity in addressing Olmstead issues. The Council's Executive Subcommittee includes the deputy directors administering long term support (and other key support) programs within these departments.

Del Norte Area 1 Agency on Aging (A1AA), a private, non-profit corporation, is responsible for a wide range of activities on behalf of older persons and adults with disabilities in Humboldt and DN County, including advocacy, planning, program development and coordination, service contracting and

monitoring service quality. A1AA has worked pro-actively with the local ILC, Caregiver Resource Center, community college and other groups on activities that strengthen HCB services to assist older persons and adults with disabilities in leading continued independent and meaningful lives.

The DN proposal involves a partnership between DN County Department of Social Services programs (such as IHSS, Adult Protective Services, A1AA's assistance in Medi-Cal eligibility determination, income and social support programs) and A1AA, responsible for all Older Americans Act, Older Californian's Act, and the Respite Registry programs. This relationship ensures that these entities have authority over core programs involved in the Resource Center. They also have strong working relationships with the other committed partnering local agencies that will assure a successful Resource Center organizational and operational structure.

San Diego AIS has been recognized at the national level for having one of the most comprehensive sets of services within an AAA. Services include:

- Information, Referral and Assistance Services: through AIS Call Center;
- Home and Community Based Services: Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS), Management and Assessment of Social Health Needs, HomeAssist, AIDS Waiver, Linkages;
- Protection, Advocacy & Crisis Intervention: Adult Protective Services, Mental Health Senior Teams, Ombudsman Program, Legal assistance and referrals, Public Administrator/Public Guardian;
- Health Independence Services: Senior Dining Centers, Health Promotion programs, home-delivered meals;
- Community Enrichment: Employment training for low incomes older adults, Older Adult Service and Information System, Retired and Senior Volunteer Program (RSVP), Senior Companions, Foster Grandparents, intergenerational programs.

- Skilled Nursing Care- Edgemoor provides 24-hour skilled nursing care, physical rehabilitation, recreational, occupational, physical and speech therapies.

Additionally, special AIS initiatives have stakeholder groups focused on and developing innovative ways to address senior and disability-related issues, such as health promotion, homelessness, transportation, protection and advocacy, and family caregiving issues. AIS's Health Promotion division currently operates Feeling Fit Clubs in senior centers throughout the community.

12. Sustainability Funding requested will support the Resource Centers' design, implementation, evaluation and some one-time resource needs. The Subgrantees have the capacity to continue the Centers after the funding terminates. New positions are not being created with grant funds. Rather, the Resource Centers will co-house staff from multiple agencies to create a more seamless set of consumer resources. With the grant tools and materials created, the sub-grantees will continue successful training and outreach efforts as well as CQI processes developed.

There is considerable CA interest in the Resource Center concept. Through the dissemination activities already noted, other local agencies interested or in the process of developing some type of Resource Center could also benefit from this grant. This information exchange could foster additional CA Resource Centers during or after the 3-year grant period.

A CA Resource Center grant, particularly of this size, will permit the State to identify the demonstrated value of establishing these Centers throughout the state; determine the fiscal costs and other resources required for replication; identify key core programs that should be included in state Aging and Disability Resource Center; educate key policymakers on the grant outcomes and gain their "buy-in" if statewide expansion is warranted.

We anticipated that this grant will also provide guidance to local and state policymakers on incremental programmatic steps that can make these programs and processes more "user friendly." While California's AAAs and ILCs and the AAAs and the Caregiver Resource Centers have been building more collaborative relationships over the past several years, co-housing services at the

Resource Centers will create new opportunities for the these networks to learn from each other's strengths and incorporate these approaches internally.

In conclusion, this grant will help CA develop effective Aging and Disability Resource Centers that are well known in the community and provide unbiased information that empowers Californians to make informed long term support choices and plan ahead for future needs. These Centers will serve California in all its diversity. But even more broadly, the investments made and lessons learned can help the state refine web based supports; forge better working relationships between health care and social support services; craft effective diversity outreach; and design strategies that are practical in urban, suburban and rural areas. These are outcomes that can positively impact every aspect of aging and long term support policy and program development within the state for years to come.

13. Letters of Commitment from Key Participating Organizations and Agencies (See Attached)